



**RI Department of Human Services
Home Modifications / Special Medical Equipment
Rental Property Agreement**

Today's date: _____

I, the owner/manager of the rental property located at:

Street: _____ Apt/floor: _____

City: _____ State: _____ Zip: _____

Occupied by:

Medicaid Recipient Name: _____

Authorize the installation of the following equipment/modifications at the above residence:

Equipment/Modifications:

By signing below, I also understand and agree with the following:

1. The equipment/modifications are for the use of the Medicaid recipient and will be removed when the recipient no longer resides in the dwelling.
2. The RI Department of Human Services (DHS) will not fund any costs associated with restoring the dwelling to the original condition.
3. Any equipment/modifications are considered the property of the Medicaid recipient.

Name of Owner/Manager (please print): _____

Signature: _____ Date: _____

Name of Medicaid Recipient (please print): _____

Signature of Recipient/Representative: _____ Date: _____